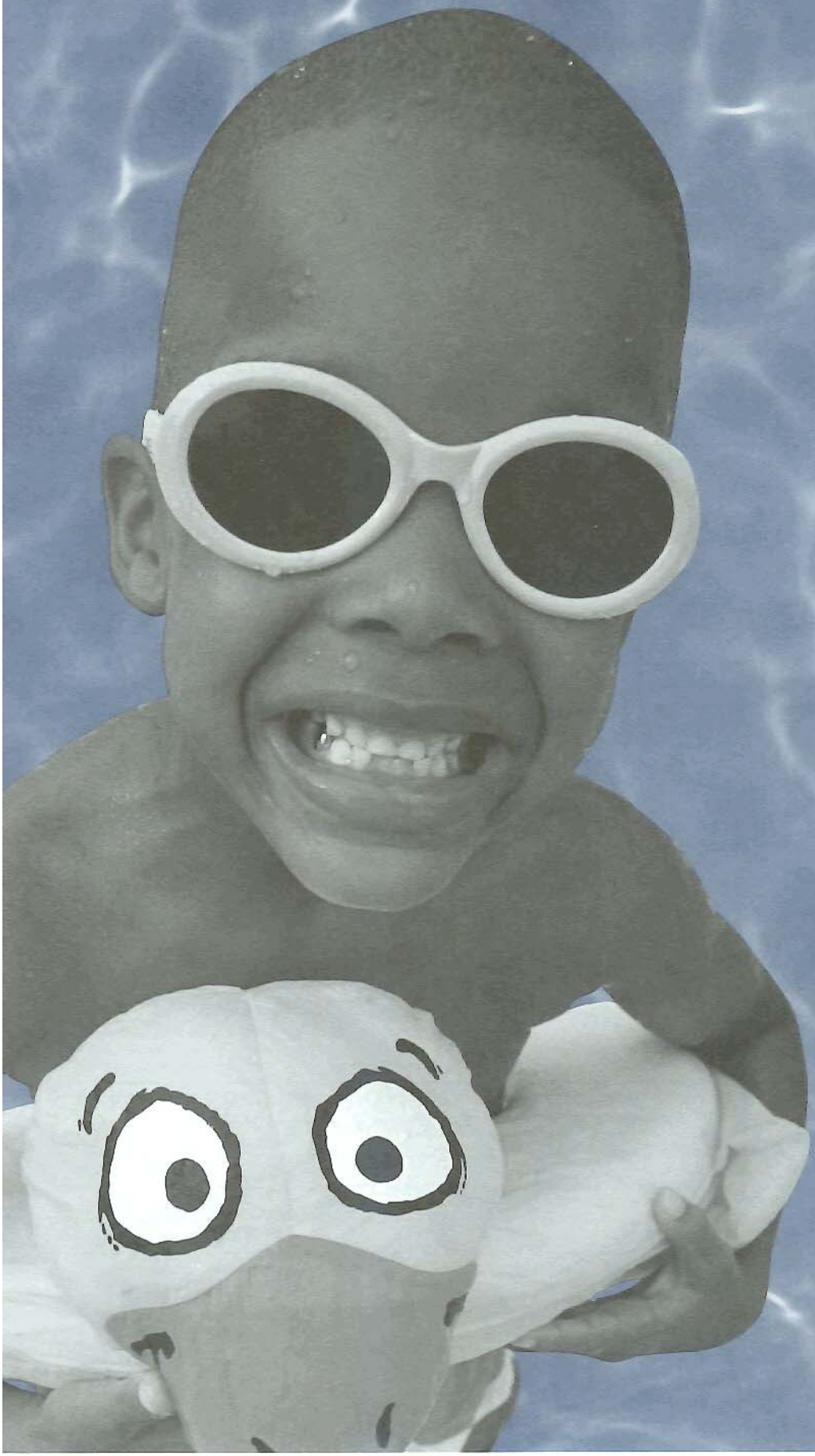
Summary of Benefits

Massachusetts
MIIA
Interlocal Insurance Association



Blue Care® Elect Preferred (PPO)

BlueCross
BlueShield
An Association of Independent Blue Cross and Blue Shield Plans

Your Choice

When You Choose Preferred Providers. You receive the highest level of benefits under your health care plan when you choose preferred providers. These are called your "in-network" benefits. You can also choose non-preferred providers, but your out-of-pocket costs are higher. These are called your "out-of-network" benefits.

Generally, you have full coverage for most preferred hospital, physician, and other provider covered services. And, for some outpatient services, you pay a **$15** copayment for each visit.

Please note: if a preferred provider refers you for covered services to another provider (such as a lab or specialist), make sure the provider you have been referred to is also a preferred provider. If the provider you use is not a preferred provider, your out-of-pocket costs will be higher, even if you are referred by a preferred provider.

How to Find a Preferred Provider. Refer to your *Provider Directory* for a comprehensive list of Massachusetts preferred providers. If you'd like assistance finding preferred providers in Massachusetts, you may also call the Member Service number on your ID card or the Physician Selection Service at **1-800-821-1388**. To check the status of a Blue Cross and/or Blue Shield preferred provider outside of Massachusetts, or for assistance in finding a Blue Cross and/or Blue Shield preferred provider, call **1-800-810-BLUE (2583)** or visit the BlueCard® website at **www.bcbs.com/healthtravel/finder.html**. If you are calling **1-800-810-BLUE (2583)**, please have your ID card ready. If you have not received your ID card, let the representative know that you are looking for providers in the BlueCard PPO (preferred provider organization) Program.

When You Choose Non-Preferred Providers. You must pay a calendar-year deductible for most out-of-network services. The deductible is **$250** for each member (or **$500** for all family members covered under the same membership). After you have met your deductible, you pay **20%** co-insurance for most out-of-network covered services. When the money paid for the 20% co-insurance equals **$1,000** for a member in a calendar year (or **$2,000** for all family members covered under the same membership), benefits for that member (or that family) will be provided in full, based on the allowed charge, for the rest of that calendar year. Refer to the benefit description and riders for a description of allowed charge and how the deductible and co-insurance are calculated.

Emergency Room Services. In an emergency, such as a suspected heart attack, stroke, or poisoning, you should go directly to the nearest medical facility or call 911 (or the local emergency phone number). You pay a **$50** copayment for in-network or out-of-network emergency room services. This copayment is waived if you are admitted to the hospital or for an observation stay.

Utilization Review Requirements. You must follow the requirements of Utilization Review, which are Pre-Admission Review, Concurrent Review and Discharge Planning, Prior Approval for Home Health Care, and Individual Case Management. Information concerning Utilization Review is detailed in your benefit description. If you need non-emergency or non-maternity hospitalization, you or someone on your behalf must call the number on your ID card for pre-approval. If you do not notify Blue Cross Blue Shield and receive pre-approval, your benefits may be reduced or denied.

Living Healthy® Programs

Blue Care Elect Preferred helps you to live as healthy a life as possible. Call us at **1-800-782-3675** and we'll send you the booklet ***Living Healthy Programs,*** which outlines how to take advantage of many special programs available to you.

LIVING HEALTHY *Babies®*	No charge
A Fitness Benefit toward membership at a health club (see your benefit description for details)	$150 per year, per individual/family
Reimbursement for a Blue Cross Blue Shield of Massachusetts designated weight loss program	$150 per year, per individual/family
Living Healthy Vision—discounts on eyewear (frames, lenses, supplies, and laser vision correction surgery)	Discount varies
Blue Care® Line to answer your health care questions 24 hours a day—call **1-888-247-BLUE (2583)**	No charge
Living Healthy Naturally—discounts for acupuncture, massage therapy, and nutritional counseling	20% discount
Visit *www.AHealthyMe.com* for an around-the-clock healthy approach to fitness, family, and fun	No charge
Member Self Service on *www.bluecrossma.com*—to help you manage your health care	No charge

Your Benefits

	YOUR COST IN-NETWORK	YOUR COST OUT-OF-NETWORK (after your deductible)
PLAN SPECIFICS		
Calendar-year deductible	None	$250 per member $500 per family
Calendar-year co-insurance maximum	None	$1,000 per member $2,000 per family
COVERED SERVICES†		
Outpatient Care		
Emergency room visits	$50 per visit (waived if admitted or for observation stay)	$50 per visit (waived if admitted or for observation stay)
Clinic visits, physicians', podiatrists', and chiropractors' office visits	$15 per visit	20% co-insurance
Well-child care visits, including related tests, according to age-based schedule as follows: • 10 visits during the first year of life • Three visits during the second year of life • One visit per calendar year from age 2 through age 11 • One visit every two calendar years from age 12 through age 18	$15 per visit	20% co-insurance
Routine adult physical exams, including related tests, according to age-based schedule as follows: • Once every five calendar years from age 19 through age 29 • Once every three calendar years from age 30 through age 39 • Once every two calendar years from age 40 through age 54 • Once every calendar year age 55 and older	$15 per visit	20% co-insurance
Routine GYN exam (one per calendar year), including related lab tests	$15 per visit	20% co-insurance
X-rays, lab tests, and other tests	Nothing	20% co-insurance
Allergy injections	$15 per visit	20% co-insurance
One routine PSA test per calendar year age 40 and older	Nothing	20% co-insurance
Routine hearing exam	$15 per visit	20% co-insurance
One routine vision exam per calendar year by an optometrist or ophthalmologist	$15 per visit	20% co-insurance
Family planning and infertility services	$15 per visit	20% co-insurance
Short-term rehabilitation therapy (up to 100 visits per calendar year)*	$15 per visit	20% co-insurance
Speech, hearing, and language disorder treatment	$15 per visit	20% co-insurance
Home health care, including hospice care	Nothing	20% co-insurance
Durable medical equipment (such as wheelchairs, crutches, hospital beds) and repairs (up to $1,500 per calendar-year)**	Charges beyond the calendar-year maximum	20% co-insurance and charges beyond the calendar-year maximum
Oxygen and equipment for its administration	Nothing	20% co-insurance
Prosthetic devices and repairs	Nothing	20% co-insurance
Surgery and related anesthesia • Office setting • Ambulatory surgical facility, hospital, or surgical day care unit	$15 per visit Nothing	20% co-insurance 20% co-insurance
Inpatient Care (including maternity care) Care in a general or chronic disease hospital for as many days as medically necessary	Nothing	20% co-insurance
Semiprivate room and board	Nothing	20% co-insurance
Care in a skilled nursing facility (up to 100 days per calendar year)	Nothing	20% co-insurance
Care in a rehabilitation hospital (up to 60 days per calendar year)	Nothing	20% co-insurance

† Any visit, day, or dollar maximums may be reduced by any benefits provided in the same calendar year under prior Blue Cross Blue Shield of Massachusetts plans.

* No visit limit applies when short-term rehabilitation therapy is furnished as part of covered home health care, or to diagnose or treat speech, hearing, and language disorders.

** No dollar limit applies when durable medical equipment is furnished as part of covered home dialysis, home health care, or hospice services.

Your Benefits (continued)

	YOUR COST IN-NETWORK	YOUR COST OUT-OF-NETWORK (after your deductible)
PLAN SPECIFICS		
Calendar-year deductible	None	$250 per member $500 per family
Calendar-year co-insurance maximum	None	$1,000 per member $2,000 per family
COVERED SERVICES†		
Mental Health and Substance Abuse Treatment		
Biologically-based conditions*		
Inpatient admissions in a general or mental hospital	Nothing	20% co-insurance
Outpatient visits	$15 per visit	20% co-insurance
Non-biologically-based mental conditions (includes drug addiction and alcoholism)		
Inpatient admissions in a general hospital	Nothing	20% co-insurance
Inpatient admissions in a mental hospital or substance abuse treatment facility (up to 60 days per calendar year)	Nothing	20% co-insurance
Outpatient visits (up to 24 visits per calendar year)	$15 per visit	20% co-insurance
Alcoholism treatment (in addition to non-biologically-based mental conditions)		
Inpatient admissions in a general hospital	Nothing	20% co-insurance
Inpatient admissions in a substance abuse treatment facility (up to 30 days per calendar year)	Nothing	20% co-insurance
Outpatient visits (up to 8 visits per calendar year)	$15 per visit	20% co-insurance
Prescription Drug Benefit		
At designated retail pharmacies (up to a 30-day formulary supply for each prescription/refill or supply)	$10 for generic** $20 for preferred brand-name $35 for non-preferred	
Through mail-service drug program (up to a 90-day formulary supply for each prescription/refill or supply)	$10 for generic** $20 for preferred brand-name $35 for non-preferred	

† Any visit, day, or dollar maximums may be reduced by any benefits provided in the same calendar year under prior Blue Cross Blue Shield of Massachusetts plans.

* Treatment for rape-related mental or emotional disorders and treatment for children under age 19 is covered to the same extent as biologically-based conditions.

** In a few instances, a generic drug or supply may be covered with a copayment other than the lowest copayment level. If you have questions about which copayment applies, ask your pharmacist or call Member Service.

Dependent and Student Benefits. Blue Care Elect Preferred covers your unmarried dependent children until age 19, or until age 26 if they are full-time students. Coverage ends when the student turns 26, or marries, or on November 1 following the date the student discontinues full-time classes or graduates, whichever comes first.

Questions? Call 1-800-782-3675

For questions about Blue Cross Blue Shield of Massachusetts, visit our website at www.bluecrossma.com

Limitations and Exclusions. These pages highlight some of the benefits of your Blue Care Elect Preferred plan. The benefit description, along with any riders, defines the terms and conditions of your coverage. Should any questions arise concerning benefits, the benefit description and riders will govern. Some of the services your plan does not cover are: custodial care; cosmetic surgery; hearing aids; most dental care; and any services covered by workers' compensation. For a complete listing of limitations and exclusions, refer to your benefit description. **Please note:** Blue Cross and Blue Shield of Massachusetts, Inc. administers claims payment only and does not assume financial risk for claims.

BlueCross BlueShield

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